Complete Summary

GUIDELINE TITLE

Pain management.

BIBLIOGRAPHIC SOURCE(S)

Horgas AL, McLennon SM. Pain management. In: Mezey M, Fulmer T, Abraham I, Zwicker DA, editor(s). Geriatric nursing protocols for best practice. 2nd ed. New York (NY): Springer Publishing Company, Inc.; 2003. p. 229-50. [46 references]

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Pain

GUIDELINE CATEGORY

Evaluation
Management
Treatment

CLINICAL SPECIALTY

Geriatrics
Nursing

INTENDED USERS

Nurses

GUIDELINE OBJECTIVE(S)

- To discuss the importance of effective pain management for elderly adults
- To describe several methods of assessing pain
- To discuss pharmacological and non-pharmacological strategies for treating pain
- To provide key points to include in education for patients and families

TARGET POPULATION

Hospitalized older adults

INTERVENTIONS AND PRACTICES CONSIDERED

Evaluation

1. Review of medical history, physical exam, laboratory and diagnostic tests
2. Pain assessment:
    - Patient and family report of intensity, character, frequency, pattern, location, duration, and precipitating and relieving factors
    - Standardized pain assessment tools:
        - Visual Analog Scale
        - Verbal Descriptor Scale
        - Faces Pain Scale
3. Review of medication use

Treatment/Management

1. Regular pain assessments and monitoring of effectiveness of medications
2. Regular administration of pain drugs, such as nonopioids (acetaminophen [Tylenol]; non-steroidal anti-inflammatory drugs [NSAIDs], such as ibuprofen [Advil, Motrin]; COX-2 inhibitors, such as celecoxib [Celebrex]; tramadol [Ultram]) and/or opioids (codeine; hydrocodone [Vicodin, Lortab]; oxycodone [Percocet, Tylox, Oxycontin]; morphine sulfate [MS Contin]; fentanyl [Duragesic]; hydromorphone [Dilaudid])
3. Consider use of nonpharmacological strategies, such as transcutaneous electrical nerve stimulation (TENS), heat/cold, massage, mild exercise, relaxation, distraction, guided imagery, hypnosis, biofeedback, prayer
4. Combination of pharmacologic and nonpharmacologic interventions
5. Treatment plan documentation
6. Patient and family/caregiver education

MAJOR OUTCOMES CONSIDERED

- Pain relief
- Quality of life

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Medline and CINAHL were the databases used.

NUMBER OF SOURCE DOCUMENTS

76

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus
Subjective Review

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not applicable

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Not stated

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Assumptions

- The majority of hospitalized elderly patients suffer from both acute and chronic pain.
- Elderly adults with cognitive impairment experience pain but are often unable to verbalize it.
- Both patients and health care providers have personal beliefs, prior experiences, insufficient knowledge, and mistaken beliefs about pain and pain management that:
    - influence the pain management process and
    - must be acknowledged and addressed before optimal pain relief can be achieved.
- Pain assessment must be regular, systematic, and documented in order to accurately evaluate treatment effectiveness.
- Self-report is the gold standard for pain assessment.

Strategies for Pain Assessment

- Review medical history, physical examinations, and laboratory and diagnostic tests in order to understand the sequence of events contributing to pain.
- Assess present pain, including intensity, character, frequency, pattern, location, duration, and precipitating and relieving factors.
- Review medications, including current and previously used prescription drugs, over-the-counter drugs, and home remedies. Determine what pain control methods have previously been effective for the patient.
- Assess patient's attitudes and beliefs about use of analgesics, anxiolytics, and nonpharmacological treatments.
- Gather information from family members about patient's pain experiences. Ask about patient's verbal and nonverbal/behavioral expressions of pain, particularly in demented patients.
- Use a standardized tool to assess self-reported pain. Choose from published measurement tools, and recall that elders may have difficulty using 10-point visual analog scales. Vertical verbal descriptor scales or faces scales may be more useful with elders, especially those with some cognitive losses.
- Assess pain regularly and frequently, but at least every 4 hours. Monitor pain intensity after giving medications to evaluate effectiveness.
- Observe for nonverbal and behavioral signs of pain, such as facial grimacing, withdrawal, guarding, rubbing, limping, shifting of position, aggression, depression, moaning, and crying. Also watch for changes in behavior from patient's usual patterns.

Nursing Care Strategies

- Prevention of pain

- Assess pain regularly and frequently to facilitate appropriate treatment.
- Anticipate and aggressively treat for pain before, during, and after painful diagnostic and/or therapeutic treatments.
- Educate patients, families, and other clinicians to use analgesic medications prophylactically prior to and after painful procedures.
- Educate patients and families about pain medications, their side effects and adverse effects, and issues of addiction, dependence, and tolerance.
- Educate patients to take medications for pain on a regular basis and to avoid allowing pain to escalate.
- Educate patients, families, and other clinicians to use nonpharmacological strategies to manage pain, such as relaxation, massage, and heat/cold.

- Treatment guidelines
  - Pharmacologic
    - Elderly adults are at increased risk for adverse drug reactions and drug--drug interactions.
    - Monitor medications closely to avoid over- or undermedication.
    - Administer pain drugs on a regular basis to maintain therapeutic levels; avoid prn drugs.
    - Document treatment plan to maintain consistency across shifts and with other care providers.
  - Nonpharmacologic
    - Investigate elderly patients' attitudes and beliefs about, preference for, and experience with nonpharmacological pain treatment strategies.
    - A variety of techniques exist, but they must be tailored to the individual.
    - Cognitive-behavioral strategies focus on changing the person's perception of pain (e.g., relaxation therapy, education, and distraction), and may not be appropriate for cognitively impaired persons.
    - Physical pain relief strategies focus on promoting comfort and altering physiologic responses to pain (e.g., heat, cold, transcutaneous electrical nerve stimulation [TENS] units).
  - A combination approach is often the best.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The recommendations were based primarily on a comprehensive review of published reports. In cases where the data did not appear conclusive, recommendations were based on the consensus opinion of the group.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Patient Will:

- Either be pain free or pain will be at a level that the patient judges as acceptable
- Maintain the highest level of self-care, functional ability, and activity level possible
- Reduce the risk of iatrogenic complications, such as falls, gastrointestinal upset/bleed, or altered cognitive status

Nurse Will:

- Demonstrate evidence of ongoing and comprehensive pain assessment
- Document evidence of prompt and effective pain management interventions
- Document systematic evaluation of intervention effectiveness
- Demonstrate knowledge of pain management in elderly patients, including assessment strategies, pain medications, nonpharmacological interventions, and patient/family education.

Institution Will:

- Provide evidence of documentation of pain assessment, intervention, and evaluation of treatment effectiveness
- Provide evidence of referral to specialists for specific therapies (e.g., psychiatry, psychology, biofeedback, physical therapy or pain treatment centers).
- Provide evidence of pain management resources for staff (e.g., care planning and pain management references, pain management consultants).

POTENTIAL HARMS

Medication Side-Effects

- Acetaminophen (Tylenol): Has few side effects and is probably the safest non-opioid for most people. Use with caution in people with underlying hepatic or renal disease; renal dysfunction may be associated with prolonged use.
- Nonsteroidal Anti-inflammatory Drugs (NSAIDs) (e.g., ibuprofen [Advil, Motrin]): Common side effect is gastric damage resulting in increased gastrointestinal tract susceptibility to injury. The elderly are more likely to develop ulcer disease and have a greater incidence of death from gastrointestinal effects of NSAIDs. Renal insufficiency is more likely to occur in the elderly with NSAID use. Use with caution with hepatic and renal disease.

  Other side effects include increased bleeding time, central nervous system effects, hepatic disease, and worsening asthma. When NSAIDs are used as single-doses, in low doses, and for short periods of time, side effects are usually less common than with long-term use. Co-administration of

misoprostol (Cytotec) has been shown to reduce the gastrointestinal complications associated with NSAID use.

- COX-2 Inhibitors (e.g., Rofecoxib, Celeoxib): Are as effective as NSAIDs for pain relief and are associated with less gastrointestinal bleeding, but have a similar risk for other side effects
- Tramadol (e.g., Ultram): Nausea and vomiting are common side effects associated with the use of tramadol, along with dizziness, sedation, restlessness, diarrhea or constipation, dyspepsia, weakness, diaphoresis, seizures, and respiratory depression. It should be used cautiously in hepatic or renal impairment.
- Opioid Drugs (e.g., codeine and morphine): Potential side effects include nausea, constipation, drowsiness, cognitive effects, and respiratory depression. Tolerance to the side effects develops with use over time; therefore coadministration of stool softeners for relief of constipation is recommended.
- Hydrocodone, Oxycodone, Morphine sulfate, MS Contin, Fentanyl, Hydromorphone: Same as codeine (see above).

CONTRAINDICATIONS

CONTRAINDICATIONS

- Tramadol should not be used in people with a history of codeine allergy.
- Medications to avoid in the elderly include meperidine (Demerol), propoxyphene (Darvon or Darvocet), and pentazocine (Talwin) because of the risk of delirium, seizures, and renal impairment. Additionally, sedatives, antihistamines, and antiemetics should be avoided or used with caution due to long duration of action, risk of falls, anticholinergic effects, and sedating effects.
- Celecoxib is contraindicated with sulfa sensitivity.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

End of Life Care
Getting Better
Living with Illness

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

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ADAPTATION

Adapted from:

- American Geriatrics Society Panel on Chronic Pain in Older Adults. (1998). The management of chronic pain in older persons. Journal of the American Geriatrics Society, 46, 635-651.
- Glen, V. L. & St. Marie, B. (2002). Overview of pharmacology. In B. St. Marie (Ed.), American Society of Pain Management Nurses: Core curriculum for pain management nursing. Philadelphia: W. B. Saunders Company.
- McCaffery, M. & Portenoy, R. (1999). Nonopiods. In M. McCaffery & C. Pasero (Eds.), Pain clinical manual (2nd ed.). St. Louis: Mosby.

DATE RELEASED

2003

GUIDELINE DEVELOPER(S)

The John A. Hartford Foundation Institute for Geriatric Nursing - Academic Institution

GUIDELINE DEVELOPER COMMENT

The guidelines were developed by a group of nursing experts from across the country as part of the Nurses Improving Care for Health System Elders (NICHE) project, under sponsorship of The John A. Hartford Foundation Institute for Geriatric Nursing.

SOURCE(S) OF FUNDING

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GUIDELINE COMMITTEE

Not stated

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Primary Authors: Ann L. Horgas, PhD, RN; Susan M. McLennon, MSN, ARNP

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: Pain management. In Mezey et al., (Eds). Geriatric nursing protocols for best practice. Springer Publishing Company: New York.

GUIDELINE AVAILABILITY

Copies of the book Geriatric Nursing Protocols for Best Practice, 2nd edition: Available from Springer Publishing Company, 536 Broadway, New York, NY 10012; Phone: (212) 431-4370; Fax: (212) 941-7842; Web: www.springerpub.com.

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

None available

NGC STATUS

This summary was completed by ECRI on February 2, 2004. The information was verified by the guideline developer on March 12, 2004. This summary was updated again on October 4, 2004 following the withdrawal of the drug Vioxx (Rofecoxib).

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